Explanation of Benefits (EOB) Numbers

Providers can use this Quick Reference Guide to find additional steps and resources to review and rectifying EOB bill denials.

How to use the reference guide:

1) On the next page, select an EOB Number hyperlink to be redirected to the specific EOB information page within this guide. The information page will show:
   - The EOB description you see on the OWCP Remittance Voucher (RV)
   - Additional steps to clarify the EOB verbiage along with links to tips, tutorials, and guides
2) Select the Return to EOB List link at the bottom right corner of your page to be redirected to the EOB menu.

Was this EOB Reference Guide helpful?
Please let us know in this two-question survey.

Explanation of Benefits (EOB) Numbers

Select an EOB Number below to navigate to the page to review the description and additional steps that need to be taken.

EOB Numbers							
20530	21731	40363	60431	80024	80105	90336	91125
20531	22733	50301	60448	80070	80906	90528	92125
20532	30275	50309	60923	80074	81070	90542	00079
20533	30598	50424	61172	80101	90125	90671	00173
20731	31589	60340	70863	80102	90128	90925	00174
21487	31598	60342	70865	80103	90138	90125	00176
00183	00184	00188	00213	00214	00236	00253	00323
00324	00344	00498	00740	00741	00742	00743	00744
00745	80010	80015	80017	80021	80031	80032	80036
80061	80062	80081	80083	80084	80085	80088	80089
80090	80415	90906	70910				

Was this EOB Reference Guide helpful?
Please let us know in this two-question survey.

Explanation of Benefits Number
Quick Reference Guide

20530
EOB NUMBER

EOB DESCRIPTION

PRIOR AUTHORIZATION REQUIRED FOR SERVICE AND NO VALID AUTHORIZATION IS ON FILE FOR CLAIMANT.

ADDITIONAL STEPS

Prior authorization required for billed service and no valid authorization is on file for claimant.

Authorizations may be submitted retroactively for services.

Refer to Provider Tips and FAQs for more information:

Authorization Tips (dol.gov)
Authorization Correction Tips (dol.gov)
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

20531
EOB NUMBER

EOB DESCRIPTION
PRIOR AUTHORIZATION IS REQUIRED FOR SERVICE AND NO VALID AUTHORIZATION IS ON FILE FOR THE PROVIDER.

ADDITIONAL STEPS
Authorization is on file for the claimant, but the OWCP provider ID assigned to the authorization does not match the billing OWCP provider ID.

Authorizations may be submitted retroactively for services.

Refer to Provider Tips and FAQs for more information:

Authorization Tips (dol.gov)
Authorization Correction Tips (dol.gov)
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

20532
EOB NUMBER

EOB DESCRIPTION
AUTH FOR CLAIMANT AND PROVIDER, NOT FOR DOS. Authorization required.

ADDITIONAL STEPS
Authorization is on file for the claimant and provider but not for the date of service being billed. Authorization request or correction must be submitted.

Authorizations may be submitted retroactively for services.

Refer to Provider Tips for more information:

Authorization Tips (dol.gov)
Authorization Correction Tips (dol.gov)
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

20533
EOB NUMBER

EOB DESCRIPTION
AUTH FOR CLAIMANT, PROVIDER, AND DOS; NOT FOR PROCEDURE. Authorization required.

ADDITIONAL STEPS
Authorization is on file for the provider, claimant, and the date of service being billed, but not for the procedure code or the procedure code modifier. Authorization request or correction must be submitted.

Authorizations may be submitted retroactively for services.

Refer to Provider Tips and FAQs for more information:

Authorization Tips (dol.gov)
Authorization Correction Tips (dol.gov)
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

20731
EOB NUMBER

EOB DESCRIPTION
UNITS AUTHORIZED ALREADY USED.

ADDITIONAL STEPS
All authorized units have already been used. Submit a new authorization request or an authorization correction to request additional units.

Refer to Provider Tips and FAQs for more information:

Authorization Tips (dol.gov)
Authorization Correction Tips (dol.gov)
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

21487
EOB NUMBER

EOB DESCRIPTION
AUTHORIZATION EXCEEDED FOR SHORT FORM CLOSURE.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC Program.

Simple/minor CA-1 traumatic injuries with no work time lost may be covered under an administrative code to cover medical expenses up to $1500 or 180 days from the date of injury. If the amount exceeds the established threshold, the claimant's case will go to formal adjudication. Providers can submit supporting documentation to U.S. Department of Labor, OWCP/DFEC, PO Box 8300, London, KY 40742-8300. Refer to the DFEC Procedure Manual | U.S. Department of Labor (dol.gov) for more information.

Refer to Division of Federal Employees' Compensation (DFEC) FAQs for more information:

Information for Medical Providers | U.S. Department of Labor (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

21731
EOB NUMBER

EOB DESCRIPTION
DOLLAR AMOUNT AUTHORIZED ALREADY USED.

ADDITIONAL STEPS
The authorized dollar amount has already been used. Submit an authorization request or an authorization correction to request additional dollars.

Refer to Provider Tips and FAQs for more information:

Authorization Tips (dol.gov)
Authorization Correction Tips (dol.gov)
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

22733
EOB NUMBER

EOB DESCRIPTION
THE LINE-ITEM UNITS OR DOLLARS AMOUNT EXCEEDS THE AUTHORIZED AMOUNT ON FILE. PLEASE REQUEST AUTHORIZATION FOR SERVICE.

ADDITIONAL STEPS
The line-item units or dollar amount exceeds the authorized amount on file. Please submit an authorization request or an authorization correction to request additional dollars.

Refer to Provider Tips for more information:

Authorization Tips (dol.gov)
Authorization Correction Tips (dol.gov)
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30275
EOB NUMBER

EOB DESCRIPTION
THE CLAIMANT IS NOT ELIGIBILE FOR FEDERAL BLACK LUNG BENEFITS.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

The claimant is not eligible for benefits under the DCMWC Program at this time.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30598
EOB NUMBER

EOB DESCRIPTION
THIS CASE IS DENIED OR CLOSED FOR THESE DATES OF SERVICE.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC Program.

This case is denied for the dates of service. The claimant may contact their Claims Examiner (CE) for further assistance.

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Explanation of Benefits Number
Quick Reference Guide

31589
EOB NUMBER

EOB DESCRIPTION
DATES OF SERVICE AFTER DATE OF DEATH

ADDITIONAL STEPS
The claimant has a date of death on file. The billed date of service is after the date of death.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

31598
EOB NUMBER

EOB DESCRIPTION
THE CLAIMANT CASE STATUS IS SET TO TERMINATED.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

The claimant is not eligible for benefits under the DCMWC Program.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

40363
EOB NUMBER

EOB DESCRIPTION
THE MODIFIER APPENDED TO THE BILLED PROCEDURE CODE IS NOT PAYABLE WITH THIS PROCEDURE. PLEASE CORRECT AND RESUBMIT.

ADDITIONAL STEPS
The modifier appended to the billed procedure code is not payable with this procedure. Please correct and resubmit.

Please refer to the OWCP Fee Schedule for more information.

OWCP Medical Fee Schedule | U.S. Department of Labor (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50301
EOB NUMBER

EOB DESCRIPTION
THE PROVIDER TYPE YOU HAVE ENROLLED WITH IS NOT AUTHORIZED FOR THIS SERVICE.

ADDITIONAL STEPS
The provider type you have enrolled with is not authorized for this service. Provider will need to revisit the billed code or review their enrollment file to reflect the correct provider type.

To update provider enrollment, refer to the Quick Reference Guide for more information:

Updating Provider Information (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50309
EOB NUMBER

EOB DESCRIPTION
THE PROVIDER ID NUMBER SUBMITTED ON THE BILL. LICENSE HAS EXPIRED.

ADDITIONAL STEPS
The license on file for the billed provider number has expired. The provider must submit updated license or certification information to update. Once the license on file is updated, the provider should resubmit the bill for processing.

To update provider enrollment, refer to the Quick Reference Guide for more information:

Updating Provider Information (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50424
EOB NUMBER

EOB DESCRIPTION
BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE.

ADDITIONAL STEPS
The provider number submitted on the bill is not active for the billed dates of service. The provider must review and submit updated information for the provider record. Once the provider file is updated, the provider should resubmit the bill for processing.

To update provider enrollment, refer to the Quick Reference Guide for more information:

Updating Provider Information (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60340
EOB NUMBER

EOB DESCRIPTION
PRIMARY CONDITION TREATED IS NOT COVERED UNDER THE BLACK LUNG PROGRAM.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

The billed diagnosis is not payable under the DCMWC Program.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60342
EOB NUMBER

EOB DESCRIPTION
THE BILLED DIAGNOSIS CODE IS NOT COVERED.

ADDITIONAL STEPS
The billed diagnosis code is not covered. Please correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60431
EOB NUMBER

EOB DESCRIPTION
PROCEDURE CODE IS NOT A COVERED SERVICE

ADDITIONAL STEPS
The billed procedure code is not a covered service. Please correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60448
EOB NUMBER

EOB DESCRIPTION
SERVICE NOT COVERED BY THE FEDERAL BLACK LUNG PROGRAM.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

The billed Revenue Center Code (RCC) on the UB-04 institutional bill is not payable for the DCMWC Program.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60923
EOB NUMBER

EOB DESCRIPTION
DIAGNOSIS NOT COVERED FOR SERVICE DATE

ADDITIONAL STEPS
The billed diagnosis is not covered for the service date. Please correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

61172
EOB NUMBER

EOB DESCRIPTION
THE REVENUE CENTER CODE, RCC BILLED REQUIRES A Current Procedural Terminology, CPT, OR Healthcare Common Procedure Coding System HCPCS CODE.THE OFFICE OF WORKERS'COMPENSATION Revenue Center Codes, RCC, CROSS-WALK IS VIEWED at OWCP Medical Fee Schedule.

ADDITIONAL STEPS
The billed Revenue Center Code (RCC) on the UB-04 institutional bill requires a procedure code and the procedure code is missing or invalid for the corresponding RCC code.

Refer to the OWCP Fee Schedule for more information

OWCP Medical Fee Schedule | U.S. Department of Labor (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

70863
EOB NUMBER

EOB DESCRIPTION
BILL DIAGNOSIS NOT RELATED TO THE ACCEPTED CONDITIONS.

ADDITIONAL STEPS
The billed diagnosis is not related to accepted conditions. If you disagree, submit medical documentation.

Refer to Provider Tips for more information:

Services for Accepted Conditions.pdf (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

70865
EOB NUMBER

EOB DESCRIPTION
SERVICE NOT COVERED. PROCEDURES ON THE BILL IS NOT RELATED TO THE ACCEPTED CONDITIONS.

ADDITIONAL STEPS
The billed procedure is not related to the accepted condition(s) on file for the claimant. If you disagree, submit medical documentation

Refer to Provider Tips for more information and details on how to submit medical documentation:

Services for Accepted Conditions.pdf (dol.gov)

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80024

EOB NUMBER

EOB DESCRIPTION

OFFICE VISIT, ESTABLISHED PATIENT, LIMITED TO 12 PER YEAR. FOR RECONSIDERATION, PLEASE RESUBMIT WITH MEDICAL JUSTIFICATION.

ADDITIONAL STEPS

The provider may rebill with supporting medical documentation.

Refer to the following links for more information:

Bill Adjustment Void Tutorial (dol.gov)
Provider Tips – OWCP Appeals vs Adjustments (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80070
EOB NUMBER

EOB DESCRIPTION
THIS PROCEDURE CODE IS USED AS AN ADD-ON TO ANOTHER PROCEDURE CODE AND THE BASE CODE WAS NOT BILLED WITH MATCHING DATE OF SERVICE.

ADDITIONAL STEPS
This procedure code is used as an add-on to another procedure code and the base code was not billed with matching dates of service.

Refer to Correct Coding Initiative (CCI) guidance for further information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80074
EOB NUMBER

EOB DESCRIPTION
THIS PROCEDURE CODE IS CONSIDERED TO BE A COMPONENT OF ANOTHER PROCEDURE BILLED FOR THE SAME DATE.

ADDITIONAL STEPS
This procedure code is considered a component of another procedure billed for the same date.

Refer to Correct Coding Initiative (CCI) guidance for further information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80101
EOB NUMBER

EOB DESCRIPTION
THIS BILL IS A DUPLICATE OF A PREVIOUSLY SUBMITTED BILL

ADDITIONAL STEPS
This bill is a duplicate of a previously submitted bill. Bill inquiry and copies of previous Remittance Vouchers (RVs) are available for your reference.

Refer to Provider Tips for more information:

Viewing Bills on the Web Portal.pdf (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80102
EOB NUMBER

EOB DESCRIPTION
THIS BILL IS A DUPLICATE OF A PREVIOUSLY SUBMITTED BILL.

ADDITIONAL STEPS
This bill is a probable duplicate, meaning that the line item posting the EOB is a probable match to another bill.

Bill inquiry and copies of previous Remittance Vouchers (RVs) are available for your reference.

Refer to Provider Tips for more information:

Viewing Bills on the Web Portal.pdf (dol.gov)

If an adjustment is required, refer to Provider Tips for more information:

Provider Tips – OWCP Appeals vs Adjustments (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80103
EOB NUMBER

EOB DESCRIPTION
THIS BILL IS A DUPLICATE OF A PREVIOUSLY SUBMITTED BILL.

ADDITIONAL STEPS
This bill is a possible duplicate, meaning that the line item posting the EOB is a possible match to another bill.

Bill inquiry and copies of previous Remittance Vouchers (RVs) are available for your reference.

Refer to Provider Tips for more information:

Viewing Bills on the Web Portal.pdf (dol.gov)

If an adjustment is required, refer to Provider Tips for more information:

Provider Tips – OWCP Appeals vs Adjustments (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80105
EOB NUMBER

EOB DESCRIPTION
THIS BILL IS A DUPLICATE OF A PREVIOUSLY SUBMITTED BILL.

ADDITIONAL STEPS
This bill is a possible duplicate, meaning that the line item posting the EOB is a possible match to another bill.

Bill inquiry and copies of previous Remittance Vouchers (RVs) are available for your reference.

Refer to Provider Tips for more information:

Viewing Bills on the Web Portal.pdf (dol.gov)

If an adjustment is required, refer to Provider Tips for more information:

Provider Tips – OWCP Appeals vs Adjustments (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80906
EOB NUMBER

EOB DESCRIPTION
Skin sealants, protectants, moisturizers or ointments are limited to 3 per 6 months

ADDITIONAL STEPS
Procedure has utilization limitations to control the number of services rendered.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

81070
EOB NUMBER

EOB DESCRIPTION
PROC IS ADD-ON BASE NOT PAID FOR SAME DOS

ADDITIONAL STEPS
Advise Caller:

Procedure code is an add-on code. The base procedure codes is not paid for the same date of service.

Refer to Correct Coding Initiative (CCI) guidance for further information.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

90125

EOB NUMBER

EOB DESCRIPTION

NURSE PROGRESS NOTE REQUIRED WITH BILL SUBMISSION OF HOME HEALTH CARE RELATED SERVICES. NURSE PROGRESS NOTES NOT PRESENT OR DO NOT MATCH BILLED SOCIAL SECURITY NUMBER AND DATE OF SERVICE

ADDITIONAL STEPS

Required attachments are missing from the submitted bill or do not match the billed claimant and date of service. Attachments must be signed by the caregiver along with the caregiver title.

Providers should correct and resubmit the bill.

Return to EOB List

90128

EOB NUMBER

EOB DESCRIPTION

BILL WAS SUBMITTED MORE THAN ONE YEAR AFTER CALENDAR YEAR IN WHICH SERVICE WAS PROVIDED OR IN WHICH CLAIM WAS FIRST ACCEPTED.

ADDITIONAL STEPS

Bill was submitted more than one year after the calendar year in which service was provided or in which claim was first accepted.

Providers can request an adjustment and submit proof of timely filing. Proof of timely filing can include a denied TCN that was submitted timely, copy of a bill RTP (returned to provider) letter, or a remittance voucher documenting timely filing.

Refer to the following links for more information:

Bill Adjustment Void Tutorial (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90138
EOB NUMBER

EOB DESCRIPTION
THE TYPE OF BILL IS MISSING/INVALID OR NOT PAYABLE FOR THE DCMWC PROGRAM.PLEASE SUPPLY THE CORRECT CODE AND RESUBMIT.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

Certain facility services are not payable based on the type of bill submitted on the UB-04 institutional bill for the DCMWC Program.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90336
EOB NUMBER

EOB DESCRIPTION
THIS BILLED LINE ITEM DENIED BECAUSE PROOF OF PURCHASE INVOICE FROM THE MANUFACTURER WAS NOT SUBMITTED.

ADDITIONAL STEPS
This billed line item denied because proof of purchase invoice from the manufacturer was not submitted.

Refer to the OWCP Fee Schedule for more information

OWCP Medical Fee Schedule | U.S. Department of Labor (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90528
EOB NUMBER

EOB DESCRIPTION
SERVICE DENIED. THE BLACK LUNG PROGRAM DOES NOT REIMBURSE FOR SERVICES WHEN BILLED AND ACCOMPANIED WITH THE SUBMITTED DIAGNOSIS CODE

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

The billed Revenue Center Code (RCC) on the UB-04 institutional bill is not payable with the submitted diagnosis for the DCMWC Program.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90542
EOB NUMBER

EOB DESCRIPTION
FECA CASE STATUS UN/UD/UE

ADDITIONAL STEPS
This EOB denial is specific to the DFEC Program.

FECA case status is Under Review or Under Development. Services are not payable during this case review timeframe.

Return to EOB List

90671

EOB NUMBER

EOB DESCRIPTION

CLAIMANT BENEFITS ARE COVERED BY A RESPONSIBLE MINE OPERATOR.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC Program.

The billed services are covered by a responsible mine operator.

Return to EOB List

90925

EOB NUMBER

EOB DESCRIPTION

Diagnostic Related Grouped, NOT COVERED BY THE FEDERAL BLACK LUNG PROGRAM.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC Program.

The acute facility services submitted on the UB-04 institutional bill are not payable for the DCMWC Program.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90125
EOB NUMBER

EOB DESCRIPTION
NURSE PROGRESS NOTE REQUIRED WITH BILL SUBMISSION OF HOME HEALTH CARE RELATED SERVICES. NURSE PROGRESS NOTES NOT PRESENT OR DO NOT MATCH BILLED SOCIAL SECURITY NUMBER AND DATE OF SERVICE

ADDITIONAL STEPS
Providers must resubmit the bill ensuring supporting documentation is attached. Attachments must be signed by the caregiver along with the caregiver title. Ensure the supporting documentation matches the billed claimant and date of service.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

91125
EOB NUMBER

EOB DESCRIPTION
NURSE PROGRESS NOTES ARE REQUIRED WITH BILL SUBMISSION OF HOME HEALTH CARE RELATED SERVICES.EITHER THE NURSE PROGRESS NOTES WERE NOT PRESENT --- OR --- NURSE NOTES DID NOT MATCH THE BILLED CLAIMANT (NAME and/or SOCIAL SECURITY NUMBER),DATE OF SERVICES,OR MISSING SIGNATURES.

ADDITIONAL STEPS
Providers must resubmit the bill ensuring supporting documentation is attached. Attachments must be signed by the caregiver along with the caregiver title. Ensure the supporting documentation matches the billed claimant and date of service.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

92125
EOB NUMBER

EOB DESCRIPTION
HOME HEALTH BILLS REVIEW ATCHMNTS

ADDITIONAL STEPS
Providers must resubmit the bill ensuring supporting documentation is attached. Attachments must be signed by the caregiver along with the caregiver title. Ensure the supporting documentation matches the billed claimant and date of service.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00079
EOB NUMBER

EOB DESCRIPTION
EVALUATION AND MANAGEMENT SERVICE REPORTED WITH MODIFIER 25,AND OTHER PROFESSIONAL SERVICES NOT REPORTED.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

MODIFIER -25 IS REPORTED FOR AN E&M PROCEDURE CODE WITH NO OPPS STATUS INDICATOR S, T, OR X PROCEDURE CODE PRESENT FOR THE SAME DATE OF SERVICE. PLEASE CORRECT AND RESUBMIT.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00173
EOB NUMBER

EOB DESCRIPTION
A SERVICE ON THE SUBMITTED BILL IS CONSIDERED TO BE APPROPRIATE ONLY IN AN INPATIENT SETTING.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

The billed procedure code is considered an Inpatient procedure and cannot be submitted on an Outpatient bill. Please correct and resubmit.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00174
EOB NUMBER

EOB DESCRIPTION
MULTIPLE EVALUATION AND MANAGEMENT VISITS SUBMITTED ON THE SAME DAY WITHOUT MODIFIER 27.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When multiple E&M codes for the same date of service are submitted on an Outpatient bill, the appropriate modifiers must be appended to the procedure code(s). Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

00176

EOB NUMBER

EOB DESCRIPTION

SUBMITTED RADIOLOGY SERVICE IS A DUPLICATE WITHIN THE SAME BILL. MODIFIER AND SUPPORTING DOCUMENTATION REQUIRED.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC Programs.

When submitting multiple radiology code on Outpatient bills, the appropriate modifier must be billed. Otherwise, duplicate code may not be payable. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

00183

EOB NUMBER

EOB DESCRIPTION

INAPPROPRIATE USE OF RIGHT AND LEFT MODIFIERS FOR THE SAME BILATERAL PROCEDURE CODE FOR THE SAME DATE OF SERVICE. CONSIDER USING MODIFIER 50

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC Programs.

When a procedure is performed on both sides of the body, consider reporting the procedure with the appropriate modifier on a single line. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00184
EOB NUMBER

EOB DESCRIPTION
DUPLICATE DIAGNOSTIC OR THERAPEUTIC PROCEDURES BILLED WITH A UNIT GREATER THAN ONE AND OR MISSING MODIFIERS.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When a billing duplicate diagnostic or therapeutic procedure codes on an Outpatient bill are processed through OPPS, the units cannot exceed the limit, and a modifier is required for some of the procedure codes. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00188
EOB NUMBER

EOB DESCRIPTION
SKIN SUBSTITUTE APPLICATION PROCEDURE BILLED WITHOUT APPROPRIATE SKIN SUBSTITUTE PRODUCT CODE.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When a billing skin substitute application procedure code on an Outpatient bill are processed through OPPS, the appropriate skin substitute HCPCS code is required. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00213
EOB NUMBER

EOB DESCRIPTION
COMPONENT PROCEDURE CODES BILLED WITH THE SAME ANATOMIC SITE MODIFIER.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

Billing procedure codes that are considered a code pair with the same modifier will suppress the NCCI editing for OPPS causing the bill lines to deny. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00214
EOB NUMBER

EOB DESCRIPTION
BILL SUBMITTED WITH ONLY INCIDENTAL SERVICES.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When submitting incidental, other payable services must be performed and billed for the same date of service. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00236
EOB NUMBER

EOB DESCRIPTION
INHERENT BILATERAL CODE, REPORT CODE ONCE. DO NOT REPORT WITH MODIFIER -50.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

Bilateral procedure codes can only be reported once. Check the procedure code indicator to determine if the code is considered bilateral. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00253
EOB NUMBER

EOB DESCRIPTION
CRITICAL CARE SERVICE REPORTED ON SAME DAY AS A SIGNIFICANT PROCEDURE THAT REQUIRES MODIFIER 25.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

For additional information on critical care service, refer to CMS.

Medicare Claims Processing Manual (cms.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00323
EOB NUMBER

EOB DESCRIPTION
PROCEDURE CODE, DIAGNOSIS CODE, REVENUE CENTER CODE OR AGE CONFLICT.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

The diagnosis submitted on the Outpatient bill is incorrect for the age of the claimant listed on the bill. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

Return to EOB List

Explanation of Benefits Number
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00324
EOB NUMBER

EOB DESCRIPTION
THE BILLED DIAGNOSIS IS INCOMPATIBLE WITH THE CLAIMANT'S SEX.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

The diagnosis submitted on the Outpatient bill is incorrect for the gender of the claimant listed on the bill. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

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Explanation of Benefits Number
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00344
EOB NUMBER

EOB DESCRIPTION
THE BILLED DIAGNOSIS IS NOT ON FILE OR INVALID.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When the Outpatient bill is processed through the 3M grouper, the diagnosis codes are validated to ensure the required digits are present. If the required diagnosis digits are missing, the bill will not be payable. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

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00498
EOB NUMBER

EOB DESCRIPTION
TRAUMA RESPONSE CRITICAL CARE CODE BILLED WITHOUT REQUIRED REVENUE CENTER CODE.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

Trauma response critical care service billed without the required revenue code and procedure code will cause the bill line to deny.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

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Explanation of Benefits Number
Quick Reference Guide

00740
EOB NUMBER

EOB DESCRIPTION
MODIFIER CA ALLOWED WITH JUST ONE INPATIENT PROCEDURE PER DAY AND REQUIRE PATIENT STATUS CODE 20

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When submitting an Outpatient bill is submitted with an inpatient only procedure, the appropriate modifier and discharge status code is required. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

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00741
EOB NUMBER

EOB DESCRIPTION
AN IMPLANTED DEVICE WAS SUBMITTED WITHOUT THE REQUIRED PARENT PROCEDURE CODE.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When submitting an Outpatient bill some devices are allowed only with certain procedure codes. If any of these devices are submitted without the parent procedure code, the line will deny in the 3M Grouper. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

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Explanation of Benefits Number
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00742
EOB NUMBER

EOB DESCRIPTION
INCORRECT TYPE OF BILL SUBMITTED ON UB-04 WITH PROCEDURE CODES G0378 & G0379 PRESENT.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When submitting an Observation service for a type of bill 13x or 85x, the appropriate revenue code and procedure code must be submitted on the bill. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

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Explanation of Benefits Number
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00743
EOB NUMBER

EOB DESCRIPTION
MULTIPLE EVALUATION AND MANAGEMENT VISITS SUBMITTED WITH THE SAME REVENUE AND OR PROCEDURE CODE ON THE SAME DAY.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

The 3M grouper will reject multiple medical visit on the same day with the same revenue code and missing condition code. Please correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

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00744
EOB NUMBER

EOB DESCRIPTION
EVALUATION AND MANAGEMENT VISIT PERFORMED ON THE SAME DAY AS A SURGICAL PROCEDURE.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

When an Outpatient bill is submitted with an E&M visit performed on the same day as a procedure code with a status indicator T or S, the appropriate modifier is required.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

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00745
EOB NUMBER

EOB DESCRIPTION
INCORRECT BILLING OF AUTOLOGOUS BLOOD-DERIVED GROWTH FACTORS, PLATELET RICH PLASMA, PROCEDURE.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

For additional information on autologous blood and transfusion, refer to CMS.

Medicare Claims Processing Manual

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80010
EOB NUMBER

EOB DESCRIPTION
ESTABLISHED OFFICE/OUTPATIENT VISIT LIMITED TO ONE PER DAY PER PAY-TO PROVIDER.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC Program.

Established E&M procedure codes 99211 through 99215 are limited to one (1) per day for the same provider. If units are exceeded, the bill line will deny.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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80015
EOB NUMBER

EOB DESCRIPTION
HOME VISIT, NEW PATIENT, LIMITED TO 1 EVERY 6 MONTHS PER PROVIDER.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

New home visit procedure codes 99341 through 99345 are limited to one (1) visit every six months for the same provider per claimant. If visit is exceeded, the bill line will deny.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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80017
EOB NUMBER

EOB DESCRIPTION
RENTAL OF PRESSURE SUPPORT VENTILATOR IS LIMITED TO 36 UNITS EVERY THREE YEARS.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

The rental of a pressure support ventilator (E0464) is limited to 36 days or units per every three (3) years per claimant. If units are exceeded, the bill line will deny.

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Explanation of Benefits Number
Quick Reference Guide

80021
EOB NUMBER

EOB DESCRIPTION

BATTERY FOR HEARING DEVICE LIMITED TO 200 UNITS PER 366 DAYS FROM THE DATE OF THE 1ST DISPENSE DATE OF SERVICE (DFEC)

BATTERY FOR HEARING DEVICE LIMITED TO 12 UNITS A YEAR. (DCMWC)

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DCMWC Programs.

- **DFEC Program**

  Battery for Hearing aid device (procedure code V5266) is limited to 200 units per every 366 days per claimant. If units are exceeded, the bill line will deny.

- **DCMWC Program**

  Battery for Hearing aid device (procedure code V5266) is limited to 12 units per every 366 days per claimant. If units are exceeded, the bill line with deny.

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80031
EOB NUMBER

EOB DESCRIPTION
CHEST XRAYS LIMITED TO TWELVE PER YEAR

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

The following Chest Xray procedure codes are limited to 12 units per year per claimant:

- 71250
- 71260
- 71045
- 71046
- 71048
- 76000 through 76001
- 71010 through 71034

If units are exceeded, the bill line will deny.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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80032
EOB NUMBER

EOB DESCRIPTION
INHALATION THERAPY FOR ACUTE OBSTRUCTION LIMITED TO SIX PER YEAR.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

Procedure codes 94640 and 94644 through 94645 are limited to six (6) units per year per claimant. If units are exceeded, the bill line will deny.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
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80036
EOB NUMBER

EOB DESCRIPTION
PROCEDURE LIMITED TO 4 EACH YEAR.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

Procedure codes 93000, 93010, and 93005 are limited to four (4) units per year per claimant. If units are exceeded, the bill line will deny.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

80061
EOB NUMBER

EOB DESCRIPTION
PROCEDURE CODE (HEARING AID FITTING/CHECKING) IS LIMITED TO 4 PER YEAR.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC Program.

Procedure code V5011 is limited to four (4) units per year per claimant. If units are exceeded, the bill line will deny.

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Explanation of Benefits Number
Quick Reference Guide

80062
EOB NUMBER

EOB DESCRIPTION
POWER MOBILITY DEVICE ONLY ALLOWED ONCE PER THREE YEARS. FOR POSSIBLE EXCEPTION, PLEASE CONTACT THE DISTRICT OFFICE.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC Program.

The following procedure codes are limited to one (1) per three (3) years per claimant.

- K0800 through K0802
- K0806 through K0808
- K0812 through K0816
- K0820 through K0831
- K0835 through K0843
- K0848 through K0871
- K0877 through K0880
- K0884 through K0886
- K0898 through K0899
- K0011 through K0012
- K0014
- E1230

If units are exceeded, the bill line will deny.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

80081
EOB NUMBER

EOB DESCRIPTION
PORTABLE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

Procedure code E0443 is limited to one (1) unit every 31 days. If units are exceeded, the bill line will deny.

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Explanation of Benefits Number
Quick Reference Guide

80083
EOB NUMBER

EOB DESCRIPTION
STATIONARY OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

Procedure code E0442 is limited to one (1) unit every 31 days per claimant. If units are exceeded, the bill line will deny.

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Explanation of Benefits Number
Quick Reference Guide

80084
EOB NUMBER

EOB DESCRIPTION
PORTABLE OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

Procedure code E0444 is limited to one (1) unit every 31 days per claimant. If units are exceeded, the bill line will deny.

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Explanation of Benefits Number
Quick Reference Guide

80085
EOB NUMBER

EOB DESCRIPTION
SERVICE IS LIMITED TO 4 ENCOUNTERS WITHIN A 12 MONTH PERIOD.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC Program.

Procedure codes 20550 through 20551 are limited to four (4) units per year per claimant. If units are exceeded, the bill line will deny.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to group not the individual procedure code.

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80088
EOB NUMBER

EOB DESCRIPTION
SERVICE IS LIMITED TO 2 UNITS PER MONTH FOR PROCEDURE CODE

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

Procedure code A4595 is limited to two (2) units per month per claimant. If units are exceeded, the bill line will deny.

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Explanation of Benefits Number
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80089
EOB NUMBER

EOB DESCRIPTION
PURCHASE OF AN OXYGEN CONCENTRATOR IS LIMITED TO ONCE EVERY THREE YEARS.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

Procedure code E1390 billed with required modifier is limited to one (1) every 1098 days per claimant. If units are exceeded, the bill line will deny.

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Explanation of Benefits Number
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80090
EOB NUMBER

EOB DESCRIPTION
RADIATION TREATMENT IS LIMITED TO 30 UNITS A YEAR.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC Program.

Procedure code E1390 billed with required modifier is limited to one (1) every 1098 days per claimant. If units are exceeded, the bill line will deny.

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80415
EOB NUMBER

EOB DESCRIPTION
PSYCHOTHERAPY THERAPY IS LIMITED TO TWO SERVICES PER CLAIMANT, PER PAY-TO-PROVIDER, PER WEEK.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC Program.

Procedure codes 90832, 90833, 90836, 90837, and 90838 are limited to two (2) units per seven (7) days per claimant. If units are exceeded, the bill line will deny.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to group not the individual procedure code.

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90906
EOB NUMBER

EOB DESCRIPTION
FREESTANDING AMBULATORY SURGERY CENTER BILLS ARE REQUIRED TO BE SUBMITTED ON A PROFESSIONAL OWCP-1500

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

ASC Provider are required to be submitted on an OWCP 1500 and appended modifier SG to avoid bill line denying.

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Quick Reference Guide

70910
EOB NUMBER

EOB DESCRIPTION
SERVICE NOT COVERED FOR CLAIMANT CASE STATUS

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC Programs.

The billed service is not included in the Claimant's accepted condition package.

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